FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0012252

Facility Name: Oak Glen Home

Address: 11210 95th Street (Number) Coal Valley (City) 61240-9721 (Zip Code)

County: Rock Island County

Telephone Number: (309) 799-3161 **Fax #** (309) 799-5904

IDPA ID Number: 36-600-6649-001

Date of Initial License for Current Owners: 09/01/1972

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sheryl Thomas **Telephone Number:** (309) 799-3161

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/1999 to 11/30/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Trudy Whittington
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) See Attached
(Firm Name & Address) Deloitte & Touche, 101 West 2nd Street, Davenport, IA 52801
(Telephone) (319) 445-9000 Fax # (319) 445-9600

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	245	Skilled (SNF)	245	89,425	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,425	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,797	2,455	2,634	18,886	8
9	SNF/PED					9
10	ICF	41,261	4,357	30	45,648	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	55,058	6,812	2,664	64,534	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.17%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 365

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: N/A Fiscal Year: November 30, 2000

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	426,289	46,555	18,732	491,576	(435)	491,141		491,141			1
2	Food Purchase		347,710		347,710		347,710		347,710			2
3	Housekeeping	217,022	31,259	7,159	255,440	(50)	255,390		255,390			3
4	Laundry	165,603	38,486	945	205,034		205,034		205,034			4
5	Heat and Other Utilities			151,540	151,540		151,540	(6,003)	145,537			5
6	Maintenance	205,142	74,442	33,903	313,487	(21,282)	292,205	(14,872)	277,333			6
7	Other (specify):*					36,080	36,080	(36,080)				7
8	**TOTAL General Services**	1,014,056	538,452	212,279	1,764,787	14,313	1,779,100	(56,955)	1,722,145			8
	B. Health Care and Programs											
9	Medical Director					15,417	15,417		15,417			9
10	Nursing and Medical Records	2,439,181	227,786	142,860	2,809,827	(105,774)	2,704,053	(1,770)	2,702,283			10
10a	Therapy	109,999	1,641	107,158	218,798	(1,503)	217,295		217,295			10a
11	Activities					125,900	125,900		125,900			11
12	Social Services	212,729	6,405	1,760	220,894	(127,350)	93,544		93,544			12
13	Nurse Aide Training					10,705	10,705		10,705			13
14	Program Transportation					2,984	2,984		2,984			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,761,909	235,832	251,778	3,249,519	(79,621)	3,169,898	(1,770)	3,168,128			16
	C. General Administration											
17	Administrative					82,799	82,799		82,799			17
18	Directors Fees							27,705	27,705			18
19	Professional Services							129,449	129,449			19
20	Dues, Fees, Subscriptions & Promotions					40,477	40,477	(29,160)	11,317			20
21	Clerical & General Office Expenses	239,951	24,923	66,765	331,639	(142,514)	189,125	6,106	195,231			21
22	Employee Benefits & Payroll Taxes			1,223,125	1,223,125		1,223,125	289,883	1,513,008			22
23	Inservice Training & Education					2,618	2,618		2,618			23
24	Travel and Seminar			4,101	4,101	927	5,028		5,028			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice							2,116	2,116			26
27	Other (specify):*											27
28	**TOTAL General Administration**	239,951	24,923	1,293,991	1,558,865	(15,693)	1,543,172	426,099	1,969,271			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,015,916	799,207	1,758,048	6,573,171	(81,001)	6,492,170	367,374	6,859,544			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Oak Glen Home #0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							66,266	66,266			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(9,522)	(9,522)		(9,522)	9,522				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					13,792	13,792	(13,792)				35
36	Other (specify):*											36
37	**TOTAL Ownership**			(9,522)	(9,522)	13,792	4,270	61,996	66,266			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					(704)	(704)		(704)			38
39	Ancillary Service Centers					67,913	67,913		67,913			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							134,138	134,138			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**					67,209	67,209	134,138	201,347			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,015,916	799,207	1,748,526	6,563,649		6,563,649	563,508	7,127,157			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(6,003)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	9,522	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(29,003)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(157)	20		28
29	Other-Attach Schedule	(56,893)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (82,534)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*	1,972	6	32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	200,404		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 202,376		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 119,842		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		$ (704)	6	38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ (704)		47

SEE ACCOUNTANTS' COMPILATION REPORT

Oak Glen Home

ID# 0012252

Report Period Beginning: 12/1/1999

Ending: 11/30/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Maintenance Expense	$ (11,593)	6	1
2	Non-medically necessary transportation	(5,251)	6	2
3	Capital Items	(36,080)	7	3
4				4
5	Offset Barber/Beauty Shop Income	(1,770)	10	5
6	Offset Rental Income	(13,792)	35	6
7	Depreciation	66,266	30	7
8	Participation Fee	134,138	42	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	131,918		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oak Glen Home # 0012252 **Report Period Beginning:** 12/1/1999 **Ending:** 11/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(6,003)	0	0	0	0	0	0	0	0	0	0	(6,003)	5
6	Maintenance	(14,872)	0	0	0	0	0	0	0	0	0	0	(14,872)	6
7	Other (specify):*	(36,080)	0	0	0	0	0	0	0	0	0	0	(36,080)	7
8	**TOTAL General Services**	(56,955)	0	0	0	0	0	0	0	0	0	0	(56,955)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,770)	0	0	0	0	0	0	0	0	0	0	(1,770)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,770)	0	0	0	0	0	0	0	0	0	0	(1,770)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	27,705	0	0	0	0	0	0	0	0	0	27,705	18
19	Professional Services	0	129,449	0	0	0	0	0	0	0	0	0	129,449	19
20	Fees, Subscriptions & Promotions	(29,160)	0	0	0	0	0	0	0	0	0	0	(29,160)	20
21	Clerical & General Office Expenses	0	6,106	0	0	0	0	0	0	0	0	0	6,106	21
22	Employee Benefits & Payroll Taxes	0	289,883	0	0	0	0	0	0	0	0	0	289,883	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,116	0	0	0	0	0	0	0	0	0	2,116	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(29,160)	455,259	0	0	0	0	0	0	0	0	0	426,099	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(87,885)	455,259	0	0	0	0	0	0	0	0	0	367,374	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oak Glen Home # 0012252 **Report Period Beginning:** 12/1/1999 **Ending:** 11/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	66,266	0	0	0	0	0	0	0	0	0	0	66,266	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	9,522	0	0	0	0	0	0	0	0	0	0	9,522	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(13,792)	0	0	0	0	0	0	0	0	0	0	(13,792)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	61,996	0	0	0	0	0	0	0	0	0	0	61,996	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	134,138	0	0	0	0	0	0	0	0	0	0	134,138	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	134,138	0	0	0	0	0	0	0	0	0	0	134,138	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	108,249	455,259	0	0	0	0	0	0	0	0	0	563,508	45

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	18	Welfare Board Member	$	Rock Island County	100.00%	$ 27,705	$ 27,705	1
2	V	19	Auditor		Rock Island County	100.00%	33,153	33,153	2
3	V	19	Treasurer		Rock Island County	100.00%	34,622	34,622	3
4	V	19	Information Systems		Rock Island County	100.00%	21,089	21,089	4
5	V	19	State's Attorney		Rock Island County	100.00%	24,055	24,055	5
6	V	19	Bid & Contract Administration		Rock Island County	100.00%	14,416	14,416	6
7	V	19	Liability Claims		Rock Island County	100.00%	2,114	2,114	7
8	V	21	County Clerk		Rock Island County	100.00%	6,106	6,106	8
9	V	22	Worker's Compensation		Rock Island County	100.00%	234,666	234,666	9
10	V	22	Insurance Administration		Rock Island County	100.00%	53,358	53,358	10
11	V	22	Unemployment Compensation		Rock Island County	100.00%	1,859	1,859	11
12	V	26	Property Insurance		Rock Island County	100.00%	2,116	2,116	12
13	V								13
14	Total			$			$ 455,259	$ * 455,259	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Kay Banfield, Chair	Chair. Nurs. Home	Director	0.00	0			Portion of Sal	$ 2,907	L18, C7	1
2	Phillip Banaszek	Nurs. Home Commit	Director	0.00	0			Portion of Salary	1,796	L18, C7	2
3	Patti Doonan	Nurs. Home Commit	Director	0.00	0			Portion of Salary	1,796	L18, C7	3
4	Johnny Ellis	Nurs. Home Commit	Director	0.00	0			Portion of Salary	1,796	L18, C7	4
5	Frank Fuhr	Nurs. Home Commit	Director	0.00	0			Portion of Salary	1,796	L18, C7	5
6	Earl Bull	Nurs. Home Commit	Director	0.00	0			Portion of Salary	1,796	L18, C7	6
7	LaVern Ohlsen	Nurs. Home Commit	Director	0.00	0			Portion of Salary	1,796	L18, C7	7
8	John Brandmeyer	Board Member	Director	0.00	0			Portion of Salary	462	L18, C7	8
9	William Armstrong	B.M., County Chair	Director	0.00	0			Portion of Salary	462	L18, C7	9
10	Rev. Gabriel Barber, III	Board Member	Director	0.00	0			Portion of Salary	462	L18, C7	10
11	Robert Bigford	Board Member	Director	0.00	0			Portion of Salary	462	L18, C7	11
12	James Bohnsack	Board Member	Director	0.00	0			Portion of Salary	462	L18, C7	12
13								TOTAL	$ 15,993		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Ted Davies	Board Member	Director	0.00	0			Portion of Sal	$ 462	L18, C7	1
2	John Dingeldein	Board Member	Director	0.00	0			Portion of Salary	462	L18, C7	2
3	Earl Bull	Board Member	Director	0.00	0			Portion of Salary	462	L18, C7	3
4	Gary Freeman	Board Member	Director	0.00	0			Portion of Salary	462	L18, C7	4
5	John Malvik	Board Member	Director	0.00	0			Portion of Salary	462	L18, C7	5
6	John Masias	Board Member	Director	0.00	0			Portion of Salary	462	L18, C7	6
7	Donald Jacob	Board Member	Director	0.00	0			Portion of Salary	462	L18, C7	7
8	Tom Rockwell	Board Member	Director	0.00	0			Portion of Salary	462	L18, C7	8
9	Fred Schultz	Board Member	Director	0.00	0			Portion of Salary	462	L18, C7	9
10	William Schultz	Board Member	Director	0.00	0			Portion of Salary	462	L18, C7	10
11	Wanda Sweat	Board Member	Director	0.00	0			Portion of Salary	462	L18, C7	11
12	Walter Tiller	Board Member	Director	0.00	0			Portion of Salary	462	L18, C7	12
13								TOTAL	$ 5,544		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Cathy Wonderlich	Board Member	Director	0.00	0			Portion of Sal	$ 462	L18, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 462		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 1/30/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Rock Island County
Street Address: 1504 Third Avenue
City / State / Zip Code: Rock Island, IL 61201
Phone Number: ((309) 786-4451
Fax Number: ((309) 786-9883

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	Welfare Board	See Attached	100		$ 27,705	$	100	$ 27,705	1
2	19	Auditor	Cost Allocation Study	100		216,684		15	33,153	2
3	19	Treasurer	Cost Allocation Study	100		161,031		22	34,622	3
4	19	Information Systems	Cost Allocation Study	100		137,570		15	21,089	4
5	19	State's Attorney	Cost Allocation Study	100		1,603,653		2	24,055	5
6	19	Bid/Contract Administration	Cost Allocation Study	100		169,605		9	14,416	6
7	19	Liability Claims	Actual Cost	100		2,114		100	2,114	7
8	21	County Clerk	Cost Allocation Study	100		34,306		18	6,106	8
9	22	Workers' Compensation	Actual Cost	100		234,666		100	234,666	9
10	22	Insurance Administration	Time Spent	100		66,697		80	53,358	10
11	22	Unemployment Insurance	Actual Cost	100		1,859		100	1,859	11
12	26	Property Insurance	Actual Cost	100		2,116		100	2,116	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,658,006	$		$ 455,259	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Schedule N/A; no loans						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	Schedule N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,498 B. General Construction Type: Exterior _____ Frame Block & Brick Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Not Applicable

Note for Section XI below: Land for Oak Glen Home was donated to Rock Island County in the early 1900's. No cost was incurred by the home, nor was any cost assigned by an outside appraisal firm in the 1970's.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Operations	280 Acres		$	1
2					2
3	TOTALS	#VALUE!		$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	245		1954	1954	$ 384,212	$		$	$	$ 384,212	4
5			1966	1966	1,900					1,900	5
6			1967	1967	601,561					601,561	6
7			1969	1969	174,960					174,960	7
8			1972	1972	8,370					8,370	8
	Improvement Type**										
9				1977	68,095					68,095	9
10				1978	112,084					112,084	10
11				1979	30,741					30,741	11
12				1980	5,464					5,464	12
13				1981	4,167					4,167	13
14				1982	40,602	1,921		1,921		36,270	14
15				1983	61,882	2,658		2,658		54,754	15
16				1984	128,384	5,573		5,573		91,816	16
17				1985	34,973	1,749		1,749		27,110	17
18				1986	35,995	1,775		1,775		26,271	18
19				1987	36,101	672		672		31,740	19
20				1988	2,590	123		123		1,548	20
21				1989	22,670	907		907		10,050	21
22				1990	16,161	808		808		8,217	22
23				1991	3,100	310		310		2,815	23
24				1992	10,089	659		659		5,402	24
25				1993	16,131	807		807		6,189	25
26				1994	15,172	759		759		4,691	26
27				1995	61,654	3,083		3,083		16,673	27
28	Elevator repair and improvement			1996	2,620	175		175		773	28
29	Replacement windows and asbestos abatement			1997	14,800	740		740		2,479	29
30	Painting of water tower			1998	69,995	7,000		7,000		16,202	30
31	Asphalt for parking lot and new sign			1999	27,402	3,262		3,262		3,855	31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,991,875	$ 32,981		$ 32,981	$	$ 1,738,409	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1998	1998	$ 36,575	$ 1,829		$ 1,829	$	$ 4,261	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 36,575	$ 1,829		$ 1,829	$	$ 4,261	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 287,548	$ 27,316	$ 27,316	$		$ 166,520	37
38	Current Year Purchases	37,994	4,140	4,140			4,140	38
39	Fully Depreciated Assets	199,942					199,942	39
40								40
41	TOTALS	$ 525,484	$ 31,456	$ 31,456	$		$ 370,602	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient-Care	1988 Ford E350 Wheelchair V	1988	$ 25,917	$	$	$		$ 25,917	42
43										43
44										44
45										45
46	TOTALS			$ 25,917	$	$	$		$ 25,917	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,579,851	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 66,266	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 66,266	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,139,189	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Vehicles	$ 94,561	$ 7,804	$ 75,560	52
53	Non patient residence	69,858			53
54	Revenue sharing assets	109,876			54
55					55
56					56
57	TOTALS	$ 274,295	$ 7,804	$ 75,560	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 13,792 Description: See attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		1,711		1,711
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		7,894		7,894
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		1,100		1,100
9	TOTALS	$	$ 10,705	$	$ 10,705
10	SUM OF line 9, col. 1 and 2 (e)	$ 10,705			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	38
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	42

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C6	# of prescrpts			67,913			67,913	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 67,913	$		$ 67,913	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 177,229	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	19,714		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	216,000		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	759,486		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,172,429	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,172,429	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 166,741	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	400		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	419,085		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached	343,650		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 929,876	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 929,876	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 242,553	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,172,429	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (298,081)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (298,081)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	355,379	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Audit Adjustments**	(45,262)	15
16	Other (describe) **Miscellaneous Closing Entries**	230,517	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 540,634	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 242,553	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,616,694	1
2	Discounts and Allowances for all Levels	(402,064)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,214,630	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,932	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,932	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	6,337	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,770	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	34,564	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	4,639	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	704	21
22	Laundry	6,555	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 54,569	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Sale of Fixed Assets and Other**	3,897	28
28a	**Transfers from Other Govt. Units**	1,641,000	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,644,897	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,919,028	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,764,787	31
32	Health Care	3,249,519	32
33	General Administration	1,558,865	33
	B. Capital Expense		
34	Ownership	(9,522)	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,563,649	40
41	**Income before Income Taxes (line 30 minus line 40)****	355,379	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 355,379	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,708	2,171	$ 41,007	$ 18.89	1
2	Assistant Director of Nursing	2,585	3,331	58,147	17.46	2
3	Registered Nurses	12,126	13,304	224,348	16.86	3
4	Licensed Practical Nurses	52,704	59,358	783,649	13.20	4
5	Nurse Aides & Orderlies	124,029	140,033	1,281,261	9.15	5
6	Nurse Aide Trainees	2,971	2,964	17,843	6.02	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,678	9,141	109,476	11.98	8
9	Activity Director	1,845	2,187	33,232	15.20	9
10	Activity Assistants	8,632	9,835	92,667	9.42	10
11	Social Service Workers	7,097	8,029	87,719	10.93	11
12	Dietician					12
13	Food Service Supervisor	3,544	4,229	50,894	12.03	13
14	Head Cook	7,634	8,399	81,326	9.68	14
15	Cook Helpers/Assistants	4,512	5,390	48,333	8.97	15
16	Dishwashers	26,540	29,422	246,008	8.36	16
17	Maintenance Workers	13,361	15,735	205,506	13.06	17
18	Housekeepers	19,280	22,667	217,545	9.60	18
19	Laundry	14,129	17,207	165,091	9.59	19
20	Administrator	1,730	1,892	42,245	22.33	20
21	Assistant Administrator	1,660	2,076	40,554	19.53	21
22	Other Administrative	1,141	1,161	17,297	14.90	22
23	Office Manager					23
24	Clerical	10,467	12,108	130,999	10.82	24
25	Vocational Instruction	512	487	8,553	17.56	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,087	3,247	31,907	9.83	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	328,972	374,373	$ 4,015,607 *	$ 10.73	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	453	$ 13,985	L1, C3	35
36	Medical Director	12 months	15,417	L9, C5	36
37	Medical Records Consultant	3	75	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12 months	1,260	L10, C3	39
40	Physical Therapy Consultant	848	47,393	L10a, C3	40
41	Occupational Therapy Consultant	877	47,838	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	49	2,425	L10a, C3	43
44	Activity Consultant	9	585	L12, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,239	$ 128,978		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	4,449	83,365	L10, C3	52
53	TOTAL (lines 50 - 52)	4,449	$ 83,365		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Trudy Whittington	Administrator	0	$ 42,245
Sheryl Thomas	Asst. Administrator	0	40,554
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 82,799

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 234,666
Unemployment Compensation Insurance	1,859
FICA Taxes	298,172
Employee Health Insurance	640,687
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	257,377
Insurance Administration	53,358
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,486,119

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,500
Health Care Worker Background Check (Indicate # of checks performed 92)	1,104
Subscriptions, Dues & Fees	31,564
NAEIR Dues & Fees	709
County Nursing Home Association	2,450
UHF Purchasing Services	150
Less: Public Relations Expense	( )
Non-allowable advertising	(29,003)
Yellow page advertising	(157)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,317

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	332
Seminar Expense	4,696
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,028

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/1999 Ending: 11/30/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **County Nursing Home Assoc. - $2450**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **48,848** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **134,138**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **Yes** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **Yes** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **2,089**
c. What percent of all travel expense relates to transportation of nurses and patients? **90%**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Deloitte & Touche LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **See Attachment**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.